

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 2-26-04.

The IRO reviewed therapeutic exercises, unlisted therapeutic procedures, ROM measurements (95851, 95852), hot/cold packs, paraffin bath, ultrasound, chiropractic manipulative treatment, and manual therapy techniques on 5-29-03 through 11-14-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The IRO concluded that the therapeutic exercises, ROM (95851), hot/cold packs, paraffin bath, and ultrasound were medically necessary from 5-29-03 through 8-12-03. The IRO agreed with the previous determination that the therapeutic exercise, unlisted therapy, neuromuscular ROM (95852), ROM 95851, hot/cold packs, paraffin bath, ultrasound, chiropractic manipulation, and manual therapy from 8-14-03 through 11-14-03 were not medically necessary. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 6-15-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Code 97016 billed for date of service 5-29-03 was billed @ \$25.00 and \$24.00 was paid by the carrier per EOB #939627. The requestor is seeking \$24.00; and the MAR is \$24.00. No additional reimbursement is due.

Code 97016 billed for dates of service 9-22-03, 10-7-03, 10-9-03, 10-10-03, 10-14-03, 10-16-03, 10-17-03, 10-23-03, 10-24-03, 10-28-03, 10-30-03, 10-31-03, and 11-6-03 were paid \$18.08 per day. The MAR is $\$14.47 \times 125\% = \18.09 . Recommend additional reimbursement of $\$0.01 \times 13 \text{ days} = \0.13 .

99354-25 billed for date of service 8-18-03 was denied as "N – not appropriately documented and Y – payment policy – documentation does not support billing of 99354." Daily note states requestor answered questions on surgery and time required to be off

work. Per Ingenix EncoderPro, this code is listed separately in addition to code for office visit. The MAR is $\$125.01 \times 125\% = \156.26 . Requestor is seeking \$147.00. Recommend reimbursement of \$147.00.

Code 97110 billed for date of service 9-9-03 was billed \$108.00 for three units. The carrier paid one unit with denial code “F – fee guideline MAR reduction. The daily note does not support billed amount. **RATIONALE:** Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes “one-on-one”. Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

The carrier paid code 99214 billed for date of service 9-19-03. The MAR is $\$82.59 \times 125\% = \103.24 . Recommend additional reimbursement of \$0.01.

Code E1399 billed for date of service 9-19-03 was denied as “G – unbundling, electrodes.” The daily note does not support E1399 as listed on the bill. Therefore, no review can be conducted and no reimbursement recommended.

Code 97039 billed for date of service 9-24-03 was denied as “F – the supplies/procedures billed require a description.” The daily note states “LASER 97039 cold laser” was used on this date of service. Therefore, recommend reimbursement of $\$12.08 \times 125\% = \15.10 .

Code A4454 billed for date of service 9-29-03 was billed @ \$5.00 and paid \$3.26 by the carrier. The requestor is seeking additional \$1.74. This code is valued @ \$2.61 per the 2003 DME fee schedule. Therefore, no additional reimbursement recommended.

Code 99214 billed for date of service 10-7-03 was paid \$51.61 with denial codes “H – half payment and N – not appropriately documented, documentation submitted does not support billing of 99214 office visit, does not contain key components required by Medicare payment policies.” Per Ingenix EncoderPro, this level of service requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. The daily notes support a detailed examination only. Therefore, no additional reimbursement recommended.

Code 97113 billed for dates of service 10-9-03, 10-10-03, 10-16-03, 10-17-03, 11-7-03, 11-12-03, and 11-14-03 was billed at \$130.00 for two units per day. The MAR is \$30.70

$\times 125\% = \$38.38 \times 2 = \76.76 . The carrier paid \$76.74 per day. Recommend additional reimbursement of $\$0.02 \times 7 \text{ days} = \0.14 .

Code 97113 billed for dates of service 10-23-03, 10-28-03, 10-30-03 and 11-6-03 was billed at \$195.00 for three units per day. The MAR is $\$30.70 \times 125\% = \$38.38 \times 3 = \$115.14$. The carrier paid \$115.11 per day. Recommend additional reimbursement of $\$0.03 \times 4 \text{ days} = \0.12 .

The carrier paid code 97530 billed for date of service 10-31-03. The MAR is $\$29.18 \times 125\% = \36.48 . Recommend additional reimbursement of \$0.01.

Code 93799 billed for date of service 11-4-03 was denied as “G – unbundling.” Per Rule 134.202 (4)(c) a cardiovascular test is included in the functional abilities tests of an FCE. The requestor billed for an FCE on this date of service and the carrier paid the MAR. Therefore, no additional reimbursement recommended.

Code 97110 billed for date of service 11-14-03 was denied as “G – unbundling, a portion of the description for the component code is common to the comprehensive code. The component code is not to be listed separately.” Per Ingenix EncoderPro, code 97110 is a component of the comprehensive code 97113 and is not paid separately unless an appropriate modifier is used. **RATIONALE:** Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes “one-on-one”. Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003 and in accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is applicable to dates of service 5-29-03 through 11-14-03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 17th day of November 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DETERMINATION
REVISED 10/28/04

MDR Tracking Number: M5-04-1911-01
IRO Certificate Number: 5259

June 14, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

Sincerely,

CLINICAL HISTORY

Available information suggests that this patient reports experiencing wrist and knee injury ___ while performing work related duty. The patient presented initially to her chiropractor Dr. W significant for diabetes and previous right wrist surgery in 1999 and

right knee surgery in 2002. An orthopedic report is submitted 06/30/03 from Dr. T, suggesting probable sprain of the right wrist, re-tearing of the tight medial meniscus, and

sprain of the right ankle. No evaluation of cervical or other spine injury is made. EMG and CT arthrogram is recommended for right wrist re-injury. Repeat arthroscopy is recommended for right knee. Air splint and MRI is recommended for right ankle. No reports of these procedures are provided for review. There is another orthopedic report submitted 08/12/03 from Dr. M, suggesting TFCC tear of the right wrist and forearm with recommendations for continued medication, debridement and arthroscopy only. Subsequent report submitted from Dr. T submitted 11/03/03 suggests that weight-bearing exercise should be avoided and that only aquatic exercise and therapy is indicated.

REQUESTED SERVICE(S)

Determine medical necessity for therapeutic exercise (97110), unlisted therapy (97139), neuromuscular eval.-hand (95852), ROM measurement 95851, hot-cold pack therapy (97010), paraffin bath (97018), ultrasound (97035), chiropractic manipulation (98943) and manual therapy (97140) for period in dispute 05/29/03 through 11/14/03.

DECISION

*Therapeutic and evaluation applications 97110, 95851, 97010, 97018, and 97035, are supported as medically necessary for **wrist condition** from 05/29/03 through 08/12/03 only.

All other services are denied.

RATIONALE/BASIS FOR DECISION

There appears to be some medical necessity for therapeutic treatment of the right wrist conditions through 08/12/03 but this level of care is **not supported** beyond this period. Available documentation does not support any therapeutic applications for right knee injury other than aquatic therapy as directed by Dr. T. There appears to be no evidence medical necessity for treatment of cervical or other spine conditions with these modalities during this period. As knee and wrist are considered surgical conditions, manipulation and mobilization procedures (98943 and 97140) **are not** medically necessary or are perhaps contra-indicated unless specifically approved or recommended by treating surgeons (not provided). ROM measurements (95851) do appear reasonably appropriate for evaluation purposes. However, DOP for neuromuscular evaluation of the hand (95852) is not submitted for review and cannot be determined as medically necessary at this time. Unlisted therapy (97139) appears to be mentioned only in chiropractic notes as (97039) 'cold laser therapy' and is not supported as medically necessary from the available literature.

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.

2. Hadler NM. Illness in the workplace: the challenge of musculoskeletal symptoms. *J Hand Surg Am.* 1985;10:451-456.
3. Bigos S., et. al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
4. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" [*Journal of Family Practice*](#), Dec, 2002.
5. Morton JE. Manipulation in the treatment of acute low back pain. *J Man Manip Ther* 1999; 7(4):182-189.
6. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.
7. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.